RURAL HEALTH CLINIC (RHC) BULLETIN
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Missouri MEDICAID Bulletin

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MEDICAID AND MC+ ELIGIBILITY

All eligible individuals receive either a Medicaid identification card or an MC+ identification card. MC+ refers to the statewide medical assistance program for low income pregnant women, children and uninsured parents. MC+ recipients receive their care through either the fee-for-service delivery system or the managed care delivery system, depending on where the individual resides. Individuals enrolled with a managed care health plan also receive a plan identification card form the health plan.

Each time service is provided, the recipient's eligibility should be verified. Providers can verify eligibility by using a Point-of-Service (POS) terminal or by calling the Interactive Voice Response (IVR) at 1-800-392-0938. No payment will be made for services provided on a date when the patient is not eligible. Refer to Section 1 of the Physician Manual, Recipient Conditions of Participation, for a full description of eligibility for the Medicaid and MC+ programs, ME codes, and third party insurance coverage.

MC+ MANAGED CARE HEALTH PLANS

MC+ managed care health plans provide RHC services as a benefit to their enrollees. Providers should contact the health plan for their program policies. The information contained in this bulletin refers to services provided on a fee-for-service basis.

DEFINITION OF RHC VISIT

An RHC visit is a face-to-face encounter between a patient and a core service provider in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), medical services, HCY services, family planning services, and prenatal services. Core service providers include physicians, nurse practitioners, nurse midwives, physician assistants, licensed clinical social workers, or clinical psychologists.

Non-billable encounters between a patient and a non-core service provider include, but are not limited to, administering injections only, blood pressure check only, and TB skin testing. Non-core service providers include LPNs, RNs, and non-licensed office staff.

PROGRAM LIMITATIONS

RHC core service providers are subject to the same benefit limitations and coverage restrictions that apply to services provided by non-RHC providers enrolled with Missouri Medicaid. Services that require attachments cannot be filed electronically and must be submitted as paper claims. Claims submitted without the appropriate attachment(s) are subject to denial or recoupment by the Surveillance and Utilization Review Unit, Division of Medical Services (DMS).

Please refer to the program provider manuals for program limitations for specific services. The manuals are available at the DMS web site www.dss.state.mo.us/dms.

OFFICE SURGICAL PROCEDURES

Certain surgeries have been identified as office surgical procedures that can be performed in the physician's office. These procedures must be billed with the "W1" modifier. The Medicaid fee for these services covers the physician's service and all ancillary and overhead costs associated with performing the procedure in the office setting. Providers may not bill an office visit in addition to billing a surgery code with a "W1" modifier.

Refer to Section 13.25 of the Physician Manual, Office Surgical Procedures, for additional information regarding this policy and to the appendix at the end of the manual for a list of covered office surgical procedures. The manual is available at the DMS web site www.dss.state.mo.us/dms.

VACCINE FOR CHILDREN (VFC) PROGRAM

Medicaid requires providers who administer vaccines to qualified Medicaid eligible children to enroll in the Vaccine For Children (VFC) Program. The VFC Program is administered by the Department of Health (DOH). Providers must contact the Department of Health (DOH) at the following address or telephone number to enroll:

Missouri Department of Health
Section of Vaccine - Preventable and
Tuberculosis Disease Elimination
P.O. Box 570
Jefferson City, MO 65102
800/219-3224
FAX: (573)526-5220

The vaccine is available at no cost to providers for Medicaid eligible children ages 0 through 18 years. Provider-based RHCs may bill the appropriate level Evaluation and Management code for VFC immunizations but *may not* bill an additional administration fee for any vaccine.

IMMUNIZATIONS GIVEN OUTSIDE OF VFC GUIDELINES

If an immunization is given to a Medicaid recipient who does not meet the VFC guidelines, use the standard procedure for billing injections. Provider-based RHCs should bill the *Physicians' Current Procedural Terminology* (CPT) code for the appropriate immunization.

SAFE/CARE EXAMINATIONS

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse are covered by Medicaid when performed by SAFE trained providers certified by the DOH. When applying for enrollment as a fee-for-service provider, you must attach a cover letter to the application stating that you are an approved SAFE trained provider.

SAFE/CARE examinations *may not* be billed with the RHC provider number. SAFE trained providers *must* bill for the examinations under their individual provider numbers through the Missouri Medicaid fee-for-service program. Medicaid reimbursement made to RHCs for SAFE/CARE examinations will be recouped by the Surveillance and Utilization Review Unit, DMS.

LABORATORY SERVICES

Rural Health Clinics (RHCs) are required to provide the following basic laboratory services on-site:

(1) Chemical examinations of urine by stick or tablet method or both (including urine ketones);
(2) Hemoglobin or hematocrit;
(3) B1ood glucose;
(4) Examination of stool specimens for occult blood;
(5) Pregnancy tests; and
(6) Primary culturing for transmittal to a certified laboratory. (This service is required for RHC certification but is not separately billable through any Missouri Medicaid program; reimbursement is included in the fee for the visit.)

These six laboratory services are waived from the Clinical Laboratory Improvement Amendments (CLIA). If a patient or laboratory service is referred to an independent laboratory for laboratory services beyond the six required services, the independent laboratory must bill for the service(s) through the Missouri Medicaid fee-for-service program. Laboratory services must be billed by the entity that performs the service.

HCFA 1450 UB-92 CLAIM FORM

Provider-based RHCs bill CPT or HCPCS (HCFA Common Procedure Coding System) procedure codes on the UB-92 claim form. Refer to the claim filing instructions included with this bulletin for specific information regarding the following:

Healthy Children and Youth (HCY) Program (ages 0 through 20 years): The federal government requires detailed reporting of screening and referral in the HCY program (also referred to as the EPSDT Program). Fields 24-30, 44, 67, and 80 of the UB-92 claim filing instructions contain specific information for the reporting of these services. A list of the HCY screening codes is attached.

Preventive medicine procedure codes are used for "well child" examinations performed outside the HCY periodicity schedule when the reason for seeing the child is not due to illness or injury. Fields 44 and 67 of the UB-92 claim filing instructions contain specific information for the reporting of these services. A list of the preventive medicine codes is attached.

Family Planning Services: It is important to correctly identify family planning procedures on the claim form to capture the federal portion of the Medicaid reimbursement for these services. Fields 24-30 and 67 of the UB-92 claim filing instructions contain specific information for reporting these services. Family planning and non-family planning services should not be reported on the same claim form.

Procedures Billed With Type of Service (TOS) 2: When a procedure that is billed with TOS 2 is performed at the RHC, the procedure code must be shown in field 80 and an office visit code (99201-99215) must be shown in field 44 of the UB-92 claim form. Show the charge for the procedure in field 47. The billed amount may include a charge for an office visit in addition to the fee for the procedure ***only*** if a separately identifiable evaluation and management service was provided. The total service provided must be documented in the patient's medical record and maintained at the clinic site.

(These instructions do not apply to surgical procedures billed with the "W1" modifier. Refer to the section regarding office surgical procedures on page 3 of this bulletin for additional information.)